# ATTACHMENT 1
# Prior Authorization/Request Form (PA/RF) completion instructions to be submitted with the Prior Authorization/ Birth to 3 Therapy Attachment (PA/B3)

**Element 1 — Processing Type**

Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

160 — Physical Therapy
161 — Occupational Therapy
162 — Speech and Language Pathology

**Element 2 — Recipient's Medical Assistance ID Number**

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

**Element 3 — Recipient's Name**

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid Forward card and the EVS do not match, use the spelling from the EVS.

**Element 4 — Recipient Address**

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

**Element 5 — Date of Birth**

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

**Element 6 — Sex**

Enter an "X" to specify whether the recipient is male or female.

**Element 7 — Billing Provider's Name, Address, ZIP Code**

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

**Element 8 — Billing Provider Telephone Number**

Enter the billing provider's telephone number, including the area code of the office, clinic, facility, or place of business.

**Element 9 — Billing Provider No.**

Enter the billing provider's eight-digit Medicaid provider number.

### Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

### Element 11 — Dx: Secondary

Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

### Element 12 — Start Date of SOI (not required)

### Element 13 — First Date Rx (not required)

### Element 14 — Procedure Code (not required)

### Element 15 — MOD

Enter the modifier corresponding to the type of therapy listed below:

| Therapy Type | Modifier |
|---|---|
| Occupational Therapy | OT |
| Physical Therapy | PT |
| Speech and Language Pathology | Leave blank — no modifier required |

### Element 16 — POS

Enter the number of the place of service in which therapy will *usually* be provided:

| Code | Description |
|---|---|
| 0 | Other |
| 3 | Clinic |
| 4 | Home |

### Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code:

| Alpha | Description |
|---|---|
| 1 | All other provider types |
| 9 | Rehabilitation agency |

### Element 18 — Description of Service

Enter "Birth to 3" and the type of therapy services (e.g., "Birth to 3 OT services" for occupational therapy services).

### Element 19 — QR (not required)

### Element 20 — Charges (not required)

### Element 21 — Total Charge (not required)

### Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

### Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the Prior Authorization Request Form (PA/RF) was completed and signed.

### Element 24 — Requesting Provider Signature

The signature and credentials of the provider performing the service must appear in this element. In the blank space to the right of Element 24, please indicate the start date for which services are being requested.

***DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.***